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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17753						17750					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			Queen Anne			a. STATE			Maryland		
			MARYLAND			b. CITY OR TOWN			Queen Anne		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			RURAL STEVENSVILLE			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Queenstown		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			5. AGE (In years last birthday)		
Benjamin			Franklin			Austin Jr.			December 6		
First			Middle			Last			Month		
Year			Year			Year			Year		
6. SEX			6. COLOR OR RACE			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH		
Male			White			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			May 13, 1910		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Waterman						Maryland			USA		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Benjamin F. Austin						Martha E. Hess					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.			17. INFORMANT		
(If yes, give year or dates of service)									Mrs. B.F. Austin Jr. - Queenstown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction											
INTERVAL BETWEEN ONSET AND DEATH 15 minutes											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year											
20d. INJURY OCCURRED											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (the hospital) attended the deceased from 12-3, 1966 to 12-6, 1966, that (I) (we) last saw the deceased alive on 12-3, 1966, and that death occurred at 9:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type)											
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17754

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17751

1. PLACE OF DEATH a. COUNTY QUEEN ANNE KENT NARROWS MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND QUEEN ANNE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Narrows		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Narrows	
		d. STREET ADDRESS General Delivery	
3. NAME OF DECEASED (Type or print) CHARLES First ROYAL Middle FINNEY Last		4. DATE OF DEATH Dec. 16, 1966 Month 12 Day 16 Year 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-1962
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 17 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Kent Narrows, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isreal Lee Finney		14. MOTHER'S MAIDEN NAME Margaret Harmon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Maryland State Police		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 916.0 IMMEDIATE CAUSE (a) 3rd degree Burns of DUE TO (b) Entire body Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) House in which he was burned	
20c. TIME OF INJURY Month, Day, Year Hour 1130 12-14 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
		20f. (City or town) Grasonville GA Md	(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE C. R. Layton		M.D. C. R. Layton	
EXAMINER'S NAME (Type) C. R. Layton		22. DATE SIGNED 12-18-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-20-1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery
		23d. LOCATION (City or Town) Essex, Virginia	(County) (State)
24. FUNERAL DIRECTOR Dashiell Funerals		ADDRESS Home, Easton, Maryland	
25a. REC'D BY REGISTRAR DEC 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C.

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Dec. 10, 1944

Dec. 10, 1944

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17755

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17752

1. PLACE OF DEATH a. COUNTY QUEEN ANNE KENT NARROWS MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND QUEEN ANNE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Narrows				c. LENGTH OF STAY IN lb Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				e. STREET ADDRESS General Delivery			
3. NAME OF DECEASED (Type or print) First JERRY Middle ALLEN Last FINNEY				4. DATE OF DEATH Month Dec. 16, 1966 Day 19 Year 19			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9- 13- 1963	9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isreal Lee Finney				14. MOTHER'S MAIDEN NAME Margaret Harmon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Maryland State Police Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 916.0 IMMEDIATE CAUSE (a) 3rd degree burns of entire DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) body DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) House in which he was burned					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 11:30 12/16 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Grasonville 2.A. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE C.R. Layton		EXAMINER'S NAME (Type) C.R. Layton, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Centreville, Md.		22. DATE SIGNED 12-18-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-20-1966		23b. DATE THEREOF 12-20-1966		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) Exmore, Virginia	
24. FUNERAL DIRECTOR Dashiell Funeral Home, Easton, Maryland				25a. REC'D BY REGISTRAR DATE DEC 21 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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FOR STATE HEALTH DEPT.

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17756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17753

1. PLACE OF DEATH a. COUNTY QUEEN ANNE KENT NARROWS MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Narrows		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Narrows		d. STREET ADDRESS General Delivery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAY Middle CHARLES Last FINNEY		4. DATE OF DEATH Month Dec. 16, 1966 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-25-1962
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Kent Narrows, Maryland
13. FATHER'S NAME Isreal Lee Finney		14. MOTHER'S MAIDEN NAME Margaret Harmon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> (If so, give war or dates of service) None		17. INFORMANT Maryland State Police	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3rd degree burns of DUE TO (b) Entire body DUE TO (c) Instant			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) House in which he was burned			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) House in which he was burned	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:25-11:30 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Grasonville Md		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE C. R. Layton M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) C. R. Layton		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 12-18-66		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-20-1966		23b. DATE THEREOF 12-20-1966	
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) Exmore, Virginia	
24. FUNERAL DIRECTOR Dawhiell Funeral Home, Easton, Maryland		25a. REC'D BY REGISTRAR DATE DEC 21 1966	
ADDRESS Dawhiell Funeral Home, Easton, Maryland		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2000 BY 60322 UCBAW

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17757

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17754

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>723</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL QUEENSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELYRIA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Route 50 + 301</u>		d. STREET ADDRESS <u>81 Riverside Homes</u>	
3. NAME OF DECEASED (Type or print) <u>Jimmy Bobby Glynn</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negroid</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 17, 1943</u>
9. AGE (In years lost birthday) yrs. <u>23</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Eufaula, Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Tom Harris (stepfather)</u>		14. MOTHER'S MAIDEN NAME <u>Wille</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 6 JAN 65 -</u>		16. SOCIAL SECURITY NO. <u>219-40-4248</u>	
17. INFORMANT <u>PERSONNEL OFFICER</u> Address <u>HP 35th BRIGADE, Fort George G. Meade, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury to</u> DUE TO (b) <u>Chest</u> DUE TO (c) <u>Auto Accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>One Car Accident hit Pole</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11:30</u> <u>11-16-66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>301-50th St</u>		20f. (City or town) (County) (State) <u>Queens Town OH Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C. R. Layton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>C. R. Layton</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Centerville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Dec. 21, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BROOKDALE CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>Elyria Ohio</u>	
24. FUNERAL DIRECTOR <u>Harold S. Wade, funeral, md</u>		ADDRESS	
25a. REC'D BY REGISTRAR <u>DEC 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>g Charles Judge</u>	

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Queen Anne's County		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D. Millington, Md.		c. LENGTH OF STAY IN lb 1 Year	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) At the Home of Mary Potts		e. STREET ADDRESS 413 South Liberty Street	
3. NAME OF DECEASED (Type or print) Jennie		4. DATE OF DEATH Month 12 Day 6 Year 1966	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/14/1877	
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Queen Anne's Co, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Brown		14. MOTHER'S MAIDEN NAME Emmaline Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-2985	
17. INFORMANT Mrs. Emma Carter		Address Centreville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 4672 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) Sclerosis of blood vessels - DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days 5-6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 7, 1966, to Dec. 6, 1966 , that (I) (we) last saw the deceased alive on Dec. 5, 1966 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Geza Koralewski		22b. DATE SIGNED 12-7-66	
22c. PHYSICIAN'S NAME (Type) Geza Koralewski Md.		22d. ADDRESS Millington, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/8/1966	
23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cem.		23d. LOCATION (City, town or county) (State) Centreville, Maryland	
24. FUNERAL DIRECTOR Ernest W. Wally		25a. REC'D BY REGISTRAR DEC 12 1966	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

DATE _____

17738

17738

UNITED STATES OF AMERICA



[Handwritten signature]

FOR STATE
HEALTH DEPT.

17759

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17756

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u>		c. LENGTH OF STAY IN lb <u>18 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>MARIAN</u> First <u>LANKFORD</u> Middle <u>JONES</u> Last		4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 8, 1896</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Westover, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARION LANKFORD</u>		14. MOTHER'S MAIDEN NAME <u>ELLA ELLIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>20-10-2161-B</u>	
17. INFORMANT <u>Husband</u> Address <u>W. Groscup Jones, Centreville, Maryland 21617</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Hypertensive Cardio Vascular</u> DUE TO (b) <u>Disease - Probable Ventricular</u> DUE TO (c) <u>Fibrillation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CVA - 1952</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C. R. Layton</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>C. R. Layton MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Centreville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Dec. 24, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARSON'S CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>Salisbury Wicomico Co Md.</u>
24. FUNERAL DIRECTOR <u>James H. Barton Jr., Barton Bur., Centreville, Md. 21617</u>		25. REC'D BY REGISTRAR <u>DEC 28 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>James H. Barton Jr.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0552

1352

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

17760

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

17757

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chestertown</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chestertown</u>	
b. COUNTY <u>MARYLAND</u>		b. COUNTY <u>Queen Anne</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Virginia</u> Last <u>Lloyd</u>		4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1874</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>17</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Squares</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wm. Lloyd—Chestertown, Maryland Rt. # 1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>C. Rodney Layton</u> EXAMINER'S NAME (Type) <u>C. Rodney Layton M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Centerville Md</u>	
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 7</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crumpton</u>		22d. LOCATION (City, town, or county) (State) <u>Crumpton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar A. Lane</u>		ADDRESS <u>Church Hill, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 8 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

17760

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17760

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Medical Examiner	
9. Signature of Coroner		10. Signature of Juror		11. Signature of Witness		12. Signature of Physician	
13. Signature of Medical Examiner		14. Signature of Coroner		15. Signature of Juror		16. Signature of Witness	
17. Signature of Physician		18. Signature of Medical Examiner		19. Signature of Coroner		20. Signature of Juror	
21. Signature of Witness		22. Signature of Physician		23. Signature of Medical Examiner		24. Signature of Coroner	
25. Signature of Juror		26. Signature of Witness		27. Signature of Physician		28. Signature of Medical Examiner	
29. Signature of Coroner		30. Signature of Juror		31. Signature of Witness		32. Signature of Physician	
33. Signature of Medical Examiner		34. Signature of Coroner		35. Signature of Juror		36. Signature of Witness	
37. Signature of Physician		38. Signature of Medical Examiner		39. Signature of Coroner		40. Signature of Juror	
41. Signature of Witness		42. Signature of Physician		43. Signature of Medical Examiner		44. Signature of Coroner	
45. Signature of Juror		46. Signature of Witness		47. Signature of Physician		48. Signature of Medical Examiner	
49. Signature of Coroner		50. Signature of Juror		51. Signature of Witness		52. Signature of Physician	
53. Signature of Medical Examiner		54. Signature of Coroner		55. Signature of Juror		56. Signature of Witness	
57. Signature of Physician		58. Signature of Medical Examiner		59. Signature of Coroner		60. Signature of Juror	
61. Signature of Witness		62. Signature of Physician		63. Signature of Medical Examiner		64. Signature of Coroner	
65. Signature of Juror		66. Signature of Witness		67. Signature of Physician		68. Signature of Medical Examiner	
69. Signature of Coroner		70. Signature of Juror		71. Signature of Witness		72. Signature of Physician	
73. Signature of Medical Examiner		74. Signature of Coroner		75. Signature of Juror		76. Signature of Witness	
77. Signature of Physician		78. Signature of Medical Examiner		79. Signature of Coroner		80. Signature of Juror	
81. Signature of Witness		82. Signature of Physician		83. Signature of Medical Examiner		84. Signature of Coroner	
85. Signature of Juror		86. Signature of Witness		87. Signature of Physician		88. Signature of Medical Examiner	
89. Signature of Coroner		90. Signature of Juror		91. Signature of Witness		92. Signature of Physician	
93. Signature of Medical Examiner		94. Signature of Coroner		95. Signature of Juror		96. Signature of Witness	
97. Signature of Physician		98. Signature of Medical Examiner		99. Signature of Coroner		100. Signature of Juror	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17761

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17758

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>QUEEN ANNE'S</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u> <u>17.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GUNSTON SCHOOL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> <u>Robertson</u> <u>Middleton</u>				4. DATE OF DEATH <u>December</u> <u>15</u> , 19 <u>66</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>December 3, 1879</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Headmistress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private School</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Hanson Robertson</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Fisher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-6448</u>		17. INFORMANT <u>Soo</u> Address <u>S. Atherton Middleton, Centreville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>C.R. Barton</u>				22. DATE SIGNED <u>12-15-66</u>			
EXAMINER'S NAME (Type) <u>C.R. Barton</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u>Centreville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Dec. 17, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Centreville Maryland</u>	
24. FUNERAL DIRECTOR <u>James H. Barton, Jr., Barton Bros., Centreville, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>DEC 20 1966</u>			

15751

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17762						17759					
1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u> <u>17.1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>FRANKLIN</u> ^{first} <u>AUGUSTUS</u> ^{Middle} <u>ROBERTS</u> ^{Last}						4. DATE OF DEATH <u>DECEMBER</u> ^{Month} <u>31</u> ^{Day} <u>19</u> ^{Year} <u>66</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 5 - 1908</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEERING</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>G.A. Co. MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>HENRY F. ROBERTS</u>						14. MOTHER'S MAIDEN NAME <u>ETHEL LEE WALBERT</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>218-14-6612</u>		17. INFORMANT <u>MRS. F.A. ROBERTS -</u>		Address <u>CHESTER MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>1810</u> IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Carcinoma of Bladder with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Metastatic Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>8 months</u> <u>4 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>66</u> , to <u>Dec 31</u> , 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>Dec 31</u> , 19 <u>66</u> , and that death occurred at <u>5:00</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>John R. Smith Jr.</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/2/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN R. SMITH JR.</u>						22d. ADDRESS <u>CENTREVILLE MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>JAN. 2</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OLD WYE</u>		23d. LOCATION (City, town or county) (State) <u>WYE MILLS MD.</u>			
24. FUNERAL DIRECTOR <u>Edgard L. Lane -</u>						ADDRESS <u>CHURCH HILL MD.</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the office of the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 17760

17763

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crumpton.		c. LENGTH OF STAY IN 1b 17.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First MARY Middle CATHERINE Last WILLSON		4. DATE OF DEATH Month December Day 30, Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August, 28, 1920
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 17 Days 1	IF UNDER 24 HRS. Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lewis Cohey	
14. MOTHER'S MAIDEN NAME Margaret Cohee		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	
16. SOCIAL SECURITY NO. 214-30-8319		17. INFORMANT James D. Willson, Address Crumpton, Md. 21828	
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO 175.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Adeno Rt Ovary DUE TO 2 years (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hysterectomy May 1966 Path diagnosis of Cd		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE C. Rodney Layton		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Centreville, Md	
EXAMINER'S NAME (Type) C. Rodney Layton.		DATE SIGNED 12-31-66	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 1, 1967	
22c. NAME OF CEMETERY OR CREMATORY Crumpton Cemetery		22d. LOCATION (City, town, or county) (State) Crumpton, Q.A.Co; Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Vellour		ADDRESS Millington, Md. 21651	
24a. REC'D BY REGISTRAR JAN 4 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

17764

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17761

1. PLACE OF DEATH a. COUNTY <u>Q. A.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Barclay - Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Lifetime</u>		d. STREET ADDRESS <u>1711</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Albert</u> Last <u>Winchester</u>		4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/19/98</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John L. Winchester</u>		14. MOTHER'S MAIDEN NAME <u>Annie Maria Brown?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-20-2546</u>	
17. INFORMANT <u>Ida Mae Winchester</u>		Address <u>Millington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12/12/66</u> Address (Street, city, town, or county) <u>Queenstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/16/1966</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Daniel Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Barclay, Maryland</u>	
23. FUNERAL DIRECTOR <u>Samuel W. Allen</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. DEC'D BY REGISTRAR <u>DEC 19 1966</u>		DATE <u>DEC 19 1966</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

17784

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17784

17784

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

17765

CERTIFICATE OF DEATH

17762

1. PLACE OF DEATH a. COUNTY QUEEN ANNE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville, Maryland		c. LENGTH OF STAY IN lb Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville, Maryland		d. STREET ADDRESS 106 Helton Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LENA First Middle Last WOODLAND		4. DATE OF DEATH Month Dec. Day 26, Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Centreville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Downes		14. MOTHER'S MAIDEN NAME Mary E. Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-26-1156	
17. INFORMANT George Woodland (Husband)		Address same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 420.1 Coronary occlusion massive DUE TO (b). Arteriosclerotic Heart Disease DUE TO (c). 7 yrs		INTERVAL BETWEEN ONSET AND DEATH 5 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 5, 1963 , to Dec 26, 1966 , that (I) (we) last saw the deceased alive on Dec 26, 1966 , and that death occurred at 1:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Rodney C. Layton		22b. DATE SIGNED 12-28-66	
22c. PHYSICIAN'S NAME (Type) Rodney C. Layton		22d. ADDRESS 104 S. Liberty St, Centreville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-31-1966	
23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		23d. LOCATION (City or Town) (County) (State) Centreville, Md. Queen Anne	
24. FUNERAL DIRECTOR Dashiell Funeral Home, Dover St, Easton, Md.		25a. REC'D BY REGISTRAR DATE JAN 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17766

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17763

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL QUEENSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Route 50 + 301</u>		d. STREET ADDRESS <u>17.1</u>	
3. NAME OF DECEASED (Type or print) <u>William Spencer Wright</u>		4. DATE OF DEATH <u>DEC. 16 19 66</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGROID</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 20, 1947 19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>	
11. BIRTHPLACE (State or foreign country) <u>Chesterdown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SPENCER Wright</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Louise Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>10 APR 64 - 214-46-4490</u>	
17. INFORMANT <u>PERSONNEL OFFICER</u>		Address <u>HQ. 35th BRIGADE, Fort George G. Meade, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>825.4</u> IMMEDIATE CAUSE (a) <u>Multiple Injuries to head</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>& Extremities</u> (c) <u>Auto Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>One Car accident Near Junction 301-60</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>11:50</u> p.m. <u>12-16-1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S. 501 + 50</u>		20f. (City or town) <u>Queenstown</u> (County) <u>QA Md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C. R. Layton</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>C. R. Layton</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Centreville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 23, 66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Small White, Laurel Laurel Ave</u>		23d. LOCATION (City or Town) <u>Chesterdown, Maryland</u> (County) (State)	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		DATE <u>DEC 23 1966</u>	

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "I have" and "the" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17767 CERTIFICATE OF DEATH 17764

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u>				c. LENGTH OF STAY IN 1b <u>34 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>202 N. Commerce</u>				d. STREET ADDRESS <u>202 N. Commerce</u>			
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>LEAH</u> Last <u>YATES</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>2</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 8, 1901</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chester Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Tingle</u>				14. MOTHER'S MAIDEN NAME <u>Martha</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-07-7042</u>		17. INFORMANT <u>Daughter</u> Address <u>RD #3, Box 30 Mrs. Janet Y. Sewell, Denton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinosis</u> DUE TO (b) <u>Carcinoma of Breast</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>May 3</u> , 19 <u>66</u> , to <u>Nov 2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 1</u> , 19 <u>66</u> , and that death occurred at <u>3:55</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>C. R. Layton</u>						22b. DATE SIGNED <u>18</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. R. Layton</u>						22d. ADDRESS <u>Centreville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC. 5, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>		23d. LOCATION (city, town or county) (State) <u>Centreville Maryland</u>	
24. FUNERAL DIRECTOR <u>James H. Batten Jr. Batten Bros. Centreville, Md 21617</u>				25a. REC'D BY REGISTRAR <u>DEC 7 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>James H. Batten Jr.</u>							

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